The Feasibility of Using State Economic Development Funds to Support Practice Development in Medically Underserved Areas and in the Adoption of Patient Centered Medical Homes

As Required Under Senate Bill 627

Report to the

MARYLAND GENERAL ASSEMBLY

Maryland Health Care Commission

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This report meets the reporting requirement under Chapter 575 of the 2009 Laws of Maryland (Senate Bill 627) that directs the Maryland Health Care Commission and the Maryland Department of Business and Economic Development to report to the Maryland General Assembly on (a) the feasibility of expanding the eligibility criteria of State development programs to include assistance to physician practices in medically underserved areas in the State; and (b) the feasibility of making economic development funding available for physician practices evolving to medical homes.

The MHCC acknowledges the Medical Group Management Association's assistance in obtaining practice expense for pediatric and family medicine practices.

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1.0 EXECUTIVE SUMMARY

Senate Bill 627 (Chapter 575 of the 2009 Laws of Maryland) directs the Maryland Health Care Commission (MHCC), in consultation with the Department of Business and Economic Development (DBED), to study the feasibility of making state economic development funding available to physicians for developing practices in underserved areas of the state and for adopting new practice models, such as the patient centered medical home. This charge results from the recommendations to the Governor and General Assembly by the Task Force on Health Care Access and Reimbursement and the Task Force to Review Physician Shortages in Rural Areas. The participants on these two task forces identified lack of capital and high levels of education debt as impediments to establishing practices in underserved areas or in adopting new models of care.

SB 627 authorized the Maryland Higher Education Commission (MHEC) and the Department of Health and Mental Hygiene (DHMH) to establish a new physician loan repayment program that becomes part of the existing Janet L. Hoffman Loan Assistance Repayment Program (which provides loan assistance to Maryland physicians who practice in state or local government or nonprofit agencies, serving residents in federally-defined health professional shortage areas [HPSAs]). Physicians practicing in a variety of care settings (private practice, community health center, hospital-based, or local government) are eligible to receive loan repayment assistance for practicing in a HPSA defined by DHMH under the new program because only state funds will be used. A small surcharge on the rates hospitals charge for their services under Maryland's all-payer hospital rate-setting system will finance the new program.

Many states have established loan assistance and repayment programs, but only a few states have established programs to assist in practice development. Physician loan repayment assistance programs provide assistance with medical education debt by paying a fixed amount of debt for each year of service. Practice assistance programs provide grants, loans, interest subsidies, and consulting support for establishing or expanding a practice. Practice loan assistance and loan guaranty programs could be valuable tools for attracting physicians, particularly primary care physicians, willing to practice in state defined HPSAs. The authors of this report identified a New York physician loan repayment and practice assistance program, ***Doctors Across New York***, as a possible model for a practice assistance program in Maryland. However, funds to finance a physician loan assistance repayment and practice loan assistance program more likely would come from special funds or through the hospital rating setting system, rather than from general revenue as is done in New York.

MHCC recommends deferring implementation of a practice assistance program, given the current budget challenges and the delays in establishing the new physician loan assistance repayment program. Although a practice assistance program should not immediately proceed, steps can be taken to plan and begin to deploy an expanded health care workforce to meet the

access issues identified by the two task forces. The MHCC proposes four priorities that state agencies can undertake to meet current and future needs of Maryland residents.

1. The new health professional shortage area definitions being developed by the Department of Health and Mental Hygiene (DHMH) should qualify areas of the state for participation in the physician loan assistance repayment program and in the practice assistance program, if established. The new health professional shortage area definitions will reflect Maryland, not national, norms and will address geographically-defined and income-based access problems. Using a consistent set of definitions will ensure that assistance is targeted at the areas of recognized need. ***Devising the new definitions can be completed with existing state resources, has no fiscal impact, and can be accomplished within the framework established under SB 627.***

2. The State's second priority should be to identify funding for the Maryland loan assistance repayment program. It was envisioned that up to a 0.5 percent surcharge could be applied to hospital rates via the hospital rate setting system to fund a loan repayment program. The surcharge has not been applied because CMS believes that federal law prohibits use of Medicare hospital payments from the Medicare Hospital Insurance Trust Fund for use in a physician loan repayment program. The State should focus on arranging funding for the new loan assistance repayment program by confirming at the highest level that the financing of the loan repayment program using hospital payments is not permitted. The new loan repayment assistance program, with expanded eligibility criteria, is an essential step in meeting access problems. It has broader application than a practice loan assistance and subsidy program because loan repayment can support physicians in a variety of practice settings, including community health centers and county health departments, as well as in private practice.

3. The third priority is a practice development program focusing on loan assistance and loan guaranty programs that could be useful for attracting physicians, especially primary care physicians, to health professional shortage areas in Maryland. The level of support to attract practices could be significant. MHCC estimates that family practitioners and pediatricians require from $132,000 to $255,000 per physician in start-up funds above their own equity to begin a practice. The status of passage of a final national health care reform bill increases the urgency for expanding the number of primary care practices in shortage areas. DBED's Guaranty Loan Fund and Equity Participation Investment Programs could serve as models for a practice loan assistance and loan guaranty program. The Guaranty Loan Fund and Equity Participation Investment Program could be used without a change in law, although capacity issues could exist.

4. The State should support multi-payer initiatives targeted toward financing practice innovations, such as implementation of new practice models, including the patient centered medical home. The Maryland Health Quality and Cost Council has taken the initiative in establishing a patient centered medical home pilot. Financing of the initiative should be largely through supplemental payments by health plans to participating practices. Long-term, this pilot

could lead to improved quality of care for patients at a lower overall cost. Given this objective, it is prudent to limit the new health care dollars injected into the system. The Strategic Assistance Consulting Fund (SACF) technical assistance program may be a possible vehicle for arranging consulting support to practices needing help in establishing systems and processes to address the administrative, clinical, and business operations required of a PCMH.

The possible passage of health reform bills in the U.S. Congress and signed by the President in 2010 increases the urgency for establishing physician practices that care for populations in underserved areas. Providing access to newly insured Marylanders may be difficult, given that the Maryland health care workforce is already judged inadequate in some parts of the State. A loan assistance and loan guaranty program structured on the basis of community need and awarded to practices on a competitive basis might be an approach to address the need for additional primary care physician practices.

2.0 BACKGROUND AND LEGISLATIVE CHARGE

According to the Association of American Medical Colleges (AAMC), there are eighty-five assistance programs for physicians in the United States.[1] Many of the programs leverage assistance to physicians as an incentive to practicing in health provider shortage areas or resource-limited communities. Funding for these programs comes from a variety of federal, state, community, and private sources. Medical education loan assistance repayment programs established to provide incentives to practices in the state or in a particular community are the most common initiatives.

Only a few states provide grants, loans, or loan guarantees to establish medical practices. Several compelling reasons exist for establishing a practice loan assistance and loan guaranty program. Developing a practice establishes a permanent source of care for a community. Physician loan assistance repayment programs allow physicians to exchange medical education loan payments for a fixed amount of medical service to a community. Once the period of service is complete, typically two to four years, the physician may have little reason to remain in the community. The short duration of service may not offer sufficient time for a physician to put down roots in a community.

The federal physician loan repayment program, which currently finances 50 percent of Maryland's Janet L. Hoffman Loan Assistance Repayment Program, limits eligibility to physicians practicing in non-profit organizations, such as community health centers, public health clinics, and other public institutions such as state hospitals. Although these positions may be attractive during the loan program, the positions may not be funded long-term. The likelihood that a physician will remain in the community is small if an attractive long-term position does not materialize with the organization or in private practice.

Physician loan repayment programs can only be targeted at physicians that have significant medical education debt. Although most recent medical graduates have debt, some may meet loan repayment obligations through other funds and others may not have loan obligations. An education loan repayment program would not be attractive to this group.

Loan assistance repayment programs offer advantages to recent graduates but few benefits for experienced physicians who may have tired of practice in large clinical or research settings, others that are looking to change who they treat or how care is delivered, and still others with a more entrepreneurial spirit.

The Task Force on Health Care Access and Reimbursement (HCAR Task Force) established in 2007 was charged with resolving issues of access to, and reimbursement of, physicians and other health professionals. The Task Force's first recommendation in its January 2008 report

[1] For a complete list of programs, see: http://services.aamc.org/fed_loan_pub/index.cfm?fuseaction=public.welcome&CFID=839875&CFTOKEN=71338534

addressed expanding access to physicians and promoting practice formation in health professional shortage areas in Maryland.[2] Four activities were identified to achieve the recommendation:

i. Establish an expanded loan program funded through the hospital rate-setting system;

ii. Establish tuition assistance and admission preference for medical students willing to work in provider shortage areas in the State;

iii. Provide technical assistance to medical practices willing to serve medically underserved populations or in provider shortage areas of the State; and,

iv. Encourage insurers to provide incentive payments to practices in shortage areas for technology upgrades.

Concurrent with the HCAR Task Force, the Task Force to Review Physician Shortages in Rural Areas convened to review rural health issues, particularly shortages of primary and specialty care physicians. In its final report, this Task Force also recommended expanding the loan repayment program. Although the Rural Physician Shortages Task Force did not specifically call for using economic development funds for practice expansion, it endorsed several related initiatives, including a 'Grow Your Own Program,' which would enable communities to provide financing for a qualified local medical student's education if the student agrees to return to the community to practice.[3] This Task Force also highlighted the need to establish more formal coordination among Maryland-based agencies and entities such as the Department of Business and Economic Development and the Maryland Higher Education Commission, the agency charged with administering the current loan assistance program.

The General Assembly enacted Loan Assistance Repayment and Practice Assistance for Physicians, Senate Bill 627, (Act 575 of the 2009 Laws of Maryland) in response to these Task Forces' recommendations.

Expanding the physician work force in Maryland, particularly health provider shortage areas, was the General Assembly's primary goal in passing Senate Bill 627. The bill expands eligibility for Maryland's Janet L. Hoffman Loan Assistance Repayment Program by authorizing a state-funded loan assistance and repayment program for physicians that agree to practice in health professional shortage areas designated by the Department of Health and Mental Hygiene.[4] Physicians in primary care are given first priority to the expanded loan assistance funds, but physicians in other specialties are able to participate, subject to availability of funds. The expanded program is to be financed through a surcharge on the rates charged by Maryland

[2] Health Care Access And Reimbursement Task Force, Final Report and Recommendations, December 2008
[3] Task Force To Review Physician Shortages In Rural Areas, Final Report and Recommendations, March 2009
[4] Physicians may receive between $25,000 and $30,000 per year, depending on the length of their service commitment under the Janet L. Hoffman Loan Assistance Repayment Program. The total award is capped at $120,000 per recipient. Repayment amounts did not change as a result of passage of SB 627.

hospitals under the State's all payer hospital rating setting system that is administered by the Health Services Cost Review Commission (HSCRC). Second, the bill requires the Maryland Health Care Commission (MHCC) and the Department of Business and Economic Development (DBED) to report on:

- The feasibility of expanding the eligibility criteria of State development programs to include providing assistance to physician practices in health professional shortage areas in the State; and
- The feasibility of making economic development funding available for physician practices evolving to medical homes.

Figure 1 presents a visualization of the strategy originally endorsed by the HCAR Task Force and enacted into law by SB 627. Changes to the loan assistance replacement program have not been implemented due to concerns that applying a surcharge on hospital rates for financing physician loan assistance repayment violates federal law.[5]

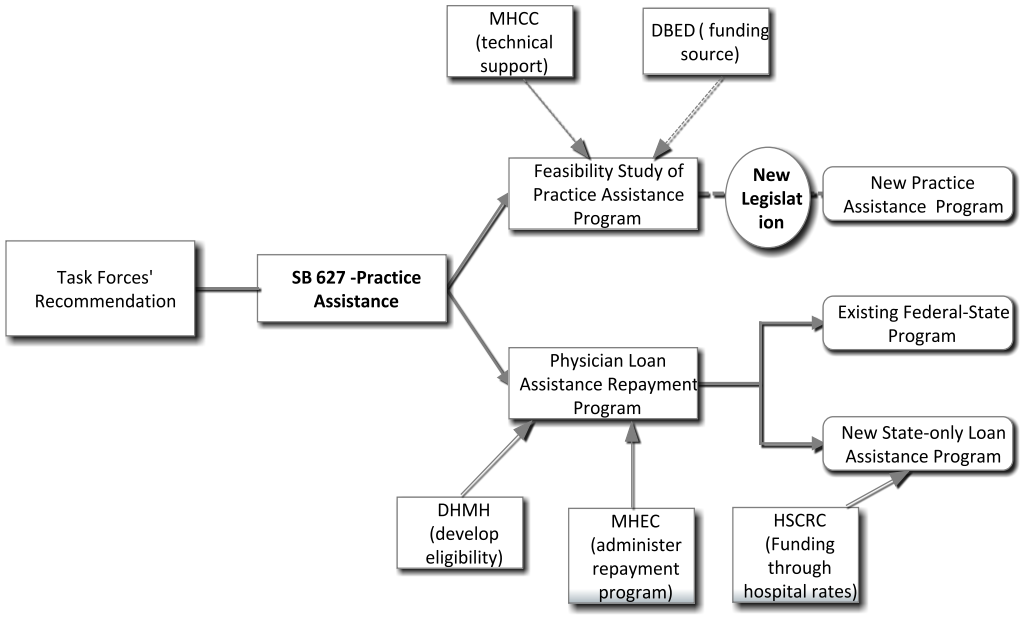
The passage of health reform bills in the U.S. Congress and the likelihood that a bill expanding access to health care will be passed and signed by the President in 2010, even in the absence of broad reform, increases the need to establish physician practices in underserved areas. Questions exist whether the Maryland health care workforce that many (though not all) observers judge to be inadequate can provide medical care to an additional 650,000 to 700,000 newly insured people.[6] A key lesson learned from the health insurance coverage expansion in Massachusetts is that universal coverage doesn't automatically equate with universal access. In a survey of Massachusetts physicians conducted by the Massachusetts Medical Society, 7 of 18 specialties reported shortages of doctors. About 40 percent of family doctors (up from 30 percent in 2007) and 56 percent of internists (up from 49 percent in 2007) said they were not accepting new patients.[7] A national insurance coverage expansion could result in similar access problems and competition for primary care physicians nationwide.

[5]Under federal law, the Hospital Insurance Trust Fund can only be used to fund hospital costs, so-called Medicare Part A payments. Physician loan repayment is defined by the federal government as Medicare Part B, which is funded through the Supplemental Medical Insurance Trust Fund.

[6] Most recent estimates completed by the MHCC using the 2009 CPS put the number of uninsured in Maryland at 715,000.

[7] MMS physician workforce study — 2009. Waltham: Massachusetts Medical Society, September 14, 2009.

Figure 1 --Evolution Of A Physician Assistance Strategy Post-National Health Reform



Three types of possible practice assistance programs could be established in Maryland. These programs are described in descending order of costliness per recipient. In a loan assistance program, the State serves as an alternative lender for practices unable to obtain credit through normal sources. Typically, these practices would be the least creditworthy. The assistance could be provided either under a loan or on a grant basis (in which case repayment would not be expected.) A loan guarantee program would require the State to commit to repaying the financial institution if the borrower defaults. The federal Small Business Administration often backs loans to small businesses under a similar arrangement. An interest subsidy program is a limited variant of the loan assistance program in which the State would "buy down" the interest rate for a conventional loan from a financial institution. The programs are not mutually exclusive. It would be feasible to offer different programs based on practice characteristics and the level of need in the community where the practice plans to locate. Interest subsidy programs have not been used recently in Maryland because loan assistance and loan guaranty programs offer more targeted and more efficient means to assist small and minority-owned businesses.[8]

[8] January 28, 2010, communications between MHCC and DBED staff.

3.0 RELEVANT PROGRAMS IN THE DEPARTMENT OF BUSINESS AND ECONOMIC DEVELOPMENT

The Maryland Department of Business and Economic Development (DBED) was established to foster job creation, assist existing businesses in expanding, facilitate development of new businesses, and promote economic development statewide. The Department manages numerous economic development programs and works closely with local governments and the private sector.

DBED has identified the two most relevant programs for practice loan assistance and technical support. While current funding levels are not adequate to finance a significant expansion, and the legal authority for lending to physician practices requires clarification, the programs may provide a framework for considering how practices might be promoted in a post-national health reform period. Each of these programs is briefly discussed below.

Maryland Small Business Development Financing Authority (MSBDFA)

The Maryland Small Business Development Financing Authority (MSBDFA) provides financing for businesses owned by economically and socially disadvantaged entrepreneurs and small employers that do not meet established credit criteria of financial institutions. MSBDFA considers the commercial and investment banks, venture capitalists, and other private lending institutions as normal financing channels. The four main programs in MSBDFA are shown in Table 1.

Table 1
Programs Currently Funded through the Maryland Small Business Development Financing Authority

Name	Purpose	Limits to any recipient
Contract Financing Program	Direct loans for working capital and the acquisition of equipment to companies with contracts with the federal, state, local governments, or public utilities	$2 Million, at interest rates from Prime to Prime +2%
Guaranty Fund Program	Loan guaranties and interest rate subsidies for loans written by financial institutions. Interest subsidies are not currently offered.	Guaranty up to 80% of loan or $2 Million.
Surety Bond Program	Surety Bonds to participate in contracting opportunities with government agencies	Guarantees up to $2.5 million
Equity Participation Investment Program	Financial assistance (loans, loan guaranties, or equity investments) for the purpose of acquiring an existing business, developing a technology-based business, or starting or expanding a franchise or other type of small businesses.	Maximum assistance up to $2 million. The applicant is required to make an equity investment.

Conventional wisdom has held that physicians are able to obtain loans from traditional lending sources. The view that physicians generally have access to capital through traditional sources seems to be supported by the lack of physician interest in loan assistance and interest subsidy programs historically. DBED analysts have noted that physician practices are not precluded from seeking assistance through the MSBDFA Program or consulting support through the Strategic Assistance Consulting Fund (SACF).[9]

Strategic Assistance Consulting Fund

The Strategic Assistance Consulting Fund provides up to $5,000 in expert private sector consulting services in specialized areas to Maryland small, minority, and micro-enterprise businesses. The fund extends the resources of public and private consultants that are part of the Maryland Small Business Development Center (MDSBDC) network by providing consulting services and training programs to current and prospective small business owners in Maryland. The following academic institutions play large consultative roles in the MDSBDC: the University of Maryland, Salisbury State University, Towson University, and College of Southern Maryland. The SACF has not been used to provide consulting services to practices in the past. The program is quite flexible, additional consultants under contract to the academic institutions or private practice consultants directly under contract to DBED could provide consulting support if additional funding is available.

4.0 ESTABLISHING A MEDICAL PRACTICE

The success of a medical practice start-up depends on a variety of factors, but the most important are gaining access to capital, factoring in the impact of competition, and managing practice costs in the face of the payer mix in the area where the practice will be located. Any organization considering financing the practice will also give careful consideration to each of these three factors.

- **Capital requirements:** Includes the start-up funding from all sources (physician's equity, private capital, and lending). Generally internists, pediatricians, family practitioners, and some medical subspecialists have low start-up costs compared to surgical specialists due to greater equipment requirements. Higher costs are typically not a significant additional impediment to launching a practice as the higher costs of starting a surgical practice are offset by higher fee-for-services payments per unit of care.[10]

[9] DBED programs have assisted a limited number of health care businesses in the past, including several medical practices and dental offices.

[10] Recent MHCC practitioner reports have documented that many private plans in Maryland reimburse evaluation and management services at or below Medicare levels, while procedures are reimbursed above Medicare levels. See the report***, 2006-2007 Practitioner Utilization, Trends Among Privately Insured Patients***, accessible at http://mhcc.maryland.gov/health_care_expenditures/exputil2009/report.pdf.

- **Competition**: Starting a practice in many areas of Maryland may be difficult because physician practices are already well-established, and starting a practice in an area with a high concentration of similarly specialized physicians can be especially challenging. Practices supported through a state economic development program would likely be situated in areas of the state that are not currently well-served by existing practitioners. Language in SB 627 directed DHMH to establishing a state-specific method for defining underserved areas that designates areas or populations in the state where unmet patient needs are greatest.[11] These criteria could be used in a loan assistance or guaranty program aimed to further practice development.

- **Payer mix:** Health Professional Shortage Areas with significant unmet health care needs in Maryland will have patient populations composed of uninsured individuals and Medicaid enrollees. Recouping health care costs given these populations will be more challenging as out-of-pocket payments and Medicaid physician reimbursement rates are less likely to cover costs. This last factor, in particular, may either discourage private lenders, or require a lender to impose conditions on a physician that makes establishing a practice difficult, or even untenable.

There are two main categories of start-up costs that might be considered for a medical practice: (1) initial fixed costs; and (2) an allowance for working capital to cover operating costs during the first year of operation, such as the cost of purchasing an initial inventory of vaccines and drugs that are prescribed to the patient.

Initial fixed costs include expenses involved in organizing and licensing the practice; initial costs of securing and outfitting the office; and costs of purchasing medical and business equipment needed to get started. Leasing office and medical equipment can greatly reduce the initial fixed costs, but that is not always possible. In addition to the initial fixed costs, the MHCC assumes a medical practice will need enough initial working capital to cover the first year of operating costs, such as utilities, insurance, salaries, medical and office supplies, telephones, and similar recurring expenses needed to stay in business. Cash flow in the early months of a new practice is limited both because patient referrals build gradually and because credentialing by carriers and hospitals takes weeks to months. Even in established medical practices, payments from third-party payers typically arrive from two weeks to six months after services have been delivered.[12] To account for the timing of reimbursement, practices typically need working capital to cover the

[11]This report does not address how underlying need affects practice location. We note that the general lack of agreement on current and projected physician requirements is due, in part, to conceptual disagreements—such as whether physician requirements should be based on a clinical definition of need, based on what society is willing to pay for, or based on some other benchmark. Disagreements also exist regarding the size and impact of trends affecting future supply and demand.

[12] Physician practices report a significant time lapse in obtaining credentials from health plans. MHCC assumes that this has improved, given changes in Maryland law that impose penalties on plans that fail to meet credentialing timeline windows. Remaining delays are hard to quantify, but are implicitly reflected as part of the working capital needs.

cost of employing the practice staff, paying the lease, and purchasing supplies. As noted above, both initial capital requirements and revenue projections vary by type of practice specialization.

5.0 ESTIMATES ON THE COSTS OF OPERATING A PHYSICAN PRACTICE

A variety of resources are used to produce health care services. Aside from the physician's own time, most costs associated with physician services are fixed costs, that is, they are not dependent on the volume of services performed at the practice. Even new practices with lower patient volumes would have operating costs that are similar to a practice that is at full capacity. This assumption means average operating costs are a reasonable proxy for the cost of starting a practice.

Studies of physician practice costs categorize expense into the broad categories shown in Table 2. Using CMS data for practice expense (based on calendar year 2000 weights adjusted by changes in the Medicare Economic Index to 2008), about 70 percent of overall expense is related to labor. Costs vary by specialty, but the average percentages accounted for by each category show that most costs associated with operating a practice are related to the work of the physician and non-physician compensation for the staff. According to these data, physician compensation accounted for about 44 percent of total expenses in 2008. Practice expenses, including the costs of staff, the facility, and supplies, accounted for 51 percent of total costs, but of that share, about half —27 percent of total expense—is non-physician compensation. Professional liability expenses account for about 5 percent of costs. Professional liability expenses differ by specialties, with liability expense for surgical specialties being considerably higher.

Table 2 – Estimated Costs Per Physician
Using CMS Practice Expense Estimates
For a Typical Practice (derived from 2008 Expenses)

Expense Category	Percentage of Expenses
Physician Work Component	44%
Wages & Salaries*	35%
Benefits* -- Fringe benefits and deferred compensation	9%
Practice Expenses	51%
Non-physician Compensation -- wages and benefits for mid-level clinical and administrative staff	27%
Other Practice Expenses -- space, medical equipment, office furniture and supplies (typically incurred through direct purchase or lease)	24%
Prof. Liability Insurance* -- the malpractice insurance premium as well as any contributions to state insurance funds or other expenses associated with insurance for malpractice incurred by the physician	5%
*Productivity adjusted using Bureau of Labor Statistics non-farm multifactor productivity, 2000 Weights adjusted to 2008, Quarter 3. Source: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group, www.cms.hhs.gov/statistics/health-indicators/t13.asp.	

The CMS information is an important starting point for the analysis of costs needed to establish a practice because it determines how the largest payer (Medicare) for many physicians values practice inputs. These data are not sufficiently precise to derive costs for Maryland primary care practices. The MHCC found that data on cost and revenue for Maryland practices are scarce or nonexistent in a form from which generalizations or inferences for policy purposes can be drawn. In fact, data on national physician practice costs are not as current or plentiful as might be expected.[13]

A limited number of other surveys on cost and revenue are available, but the information must be qualified, especially at the individual specialty level. Despite small samples sizes, specialty-specific costs are superior for purposes of analysis because of variation in revenue and expenses across specialty. Primary care practices, the principal focus of the HCAR Task Force recommendations, generate less total revenue per physician and have higher non-physician labor costs to total revenue ratios than medical subspecialists and surgical specialists.

Using recent survey data supplied by the Medical Group Management Association (MGMA), the MHCC estimated expenses for pediatrics and family medicine, two specialties likely to be included in any medical economic development program launched by the State. The expense allocation estimated by MGMA for the two specialties is shown in Table 3. Revenue and expenses are for non-hospital owned practices that submitted survey responses to MGMA. The data includes responses from practices throughout the United States, as the sample from Maryland was extremely limited. The national sample reflects the experience of practices in the membership of the MGMA – larger, private, physician-owned organizations and hospital-owned practices. For these estimates, only the expense data on physician-owned practices are used. MHCC assumes that the practices eligible for a program would be in their start-up phase, and that expected revenue would be no higher than that reported at the 10th percentile of practices that responded to the survey.[14]

The MGMA survey results show that pediatric practices at the 10th percentile produce approximately $430,000 in revenue per full-time physician, about $30,000 more in revenue than a start-up family medicine practice. Almost all of the additional revenue is attributable to higher practice expenses from pediatrician-administered vaccines and medications. However, higher expenses translate into higher start-up costs to maintain a significant inventory of vaccines and drugs to launch the practice.

[13]In 2003, the American Medical Association abandoned its Socioeconomic Monitoring Survey because of an inability to collect accurate cost and revenue information from AMA members.

[14]A report by MHCC estimated that private fee levels in Maryland were in the lowest quartile of fees among the 50 states. That report is often cited as evidence that physician incomes in Maryland are in the lowest 25 percentile. However, physician income is also affected by the volume and mix of services provided and by the payer mix (private, Medicare, Medicaid, and uninsured).

Table 3
Pediatric and Family Medicine
Revenue and Expenses per Full-time Physician
In 2008 Dollars

Expense Category	Pediatrics		Family Medicine	
Index Levels:	**Allocation of costs**	**Practice Expense**	**Allocation of costs**	**Practice Expense**
Total Revenue*	100%	**$429,364**	100%	**$401,710**
Physician Compensation	30%	**$129,250**	35%	**$139,055**
Wages & Salaries	28%	$119,100	32%	$129,324
Benefits	2%	$10,150	2%	$9,731
Practice Expenses	63%	**$271,999**	62%	**$248,646**
Non-physician Compensation	26%	$110,808	31%	**$123,411**
Other Practice Expenses	38%	$161,191	31%	**$125,235**
Prof. Liability Insurance	1%	$5,974	2%	**$6,857**

*Expense categories do not sum to total revenue because of missing data for some of the categories in the MGMA survey. Source: Medical Group Management Association, 2009 Report Based on 2008 Data. Cost data are for non-hospital owned practices. Practices include respondents across the US that responded to the MGMA survey.

Table 4 presents rough estimates of start-up costs for pediatric and family medicine practices. Two separate assumptions are made regarding the level of equity provided by the physicians to the practice. Under the first assumption, physicians invest 10 percent of start-up costs. A 10 percent minimum equity investment is commonplace in loan assistance programs. In the second assumption, owner's equity is set at 25 percent of start-up costs. The 10 percent equity requirement is consistent with a young physician just starting out in practice. A 25 percent equity share could be a reasonable expectation for practicing physicians that start a new practice and already have greater personal savings. Under both assumptions, MHCC expects that physician compensation is reflected as part of start-up costs.

Estimating the level of working capital needed to sustain the practice is a more challenging task. The amount of working capital needed to sustain a business is often expressed as a percent of accounts receivable. Working capital was estimated from expected revenue in accounts receivable for a well-established practice at the 10th percentile of the distribution on revenue per physician for each specialty. MHCC allowed the level of working capital needed to sustain the start-up to vary between a minimum of three months to a maximum of six months. These

assumptions are consistent with billing and payment practices today. Two to six months elapse between the delivery of a service and the receipt of payment from Medicare, Medicaid, or a commercial plan. New practices often have low patient volumes and little expected revenue in accounts receivable. The MHCC assumes a new practice could generate less revenue during the start-up period when patient volume is low. Credentialing and other administrative procedures required of new practices can slow patient scheduling and produce delays in payments. Nonetheless, practices' expenses would accumulate as facility leases and employee salaries must be paid.

Table 4
Potential Startup Costs for Formation of a Pediatric or Family Medicine Practice
Costs Per Full-Time Physician in 2008 Dollars

	Pediatrics		Family Medicine	
	3 months of Expected AR in Working Capital	6 months of Expected AR in Working Capital	3 months of Expected AR in Working Capital	6 months of Expected AR in Working Capital
Total Annual Expected Revenue	**$429,364**	**$429,364**	**$401,710**	**$401,710**
TOTAL Start-up Costs	**147,639**	**254,980**	**131,736**	**232,164**
Initial Fixed Costs	**40,298**	**40,298**	**31,309**	**31,309**
Working Capital	**107,341**	**214,682**	**100,428**	**200,855**
Assumption 1 Total Startup Costs Less 10% Owner's Equity	**132,875**	**229,482**	**118,563**	**208,947**
Assumption 2 Total Startup Costs less 25% Owner's Equity	**110,729**	**191,235**	**98,802**	**174,123**

Depending on assumptions for owner's equity and working capital requirements, start-up expenses for a pediatric practice would range from approximately $148,000 to $255,000 and for a family medicine practice from $131,000 to $232,000. Of those totals, approximately $31,000 to $40,000 would be allocated to costs directly associated with starting a business, including costs of re-location, deposits on office space and equipment, business/medical licenses, the costs of consultants, and advertising. These are costs that most analysts readily define as start-up costs. Total start-up funds for pediatric and family medicine practices are of a similar magnitude and pattern, but absolute levels for pediatric practices are slightly higher due to the greater vaccine and drug inventory expenses.

A physician's access to capital is a crucial step toward ensuring success. The MHCC assumes that many younger physicians likely to start a practice would already carry a significant amount of personal debt associated with medical school costs. In 2008, the average educational debt carried by recent medical school graduates was approximately $154,600.[15] Given the level of personal indebtedness, a physician's own equity position would be small. The MHCC assumes that a physician could take from a 10 to 25 percent equity position in the practice. This leaves approximately $111,000 to $229,000 in additional capital to be raised for establishing the practice. Most physicians would turn to lending institutions for this amount of capital.

The MHCC assessed if physicians face significant unmet capital needs when launching a practice. Generally, physicians have good access to capital markets or other sources of capital. The MHCC's analysis suggested that this continues to be true even in a period of tighter lending standards. Large commercial banks court physicians through their business or personal finance product lines.[16] However, access varies by market and the lack of incentives to practice in underserved areas coupled with greater difficulty in arranging credit probably deters practice placement in those areas. An informal survey identified a number of established sources for credit.

Normal Sources of Capital through Lending Institutions

Most physicians starting a practice would turn to lending institutions as a source of financing. Physicians starting a medical practice can access small business loans as well as personal loans from banks or other financial institutions. These loans are allocated based on physicians' current financial capital and their future anticipated earnings. For most physicians, particularly specialists, earning potential can be both high and quite stable. Thus, bank-issued loans are traditionally accessible to physicians, particularly those beginning a specialty practice. Generally, physicians would be viewed favorably when approaching lending institutions, particularly if those institutions operate in the same community where the physician intends to practice.

As stated earlier, physician practices generally have access to capital through normal financing arrangements. Recent tightening in the credit markets may pose challenges for physician borrowers. In the current business environment, gaining access to capital has proven more challenging for all small businesses, physician practices that have long been viewed as safe enterprises with predictable and stable cash flows may face challenges. External factors such as

[15] American Association of Medical Colleges, *2008 Graduation Questionnaire*, accessed at http://www.aamc.org/newsroom/reporter/dec08/graduates.htm.

[16] Bank of America, SunTrust, and Citibank offer practice financing programs for physicians. The Bank of America financial analysts contacted by MHCC pointed to a web portal specifically aimed at physician practices http://www.bankofamerica.com/small_business/practicesolutions/index.cfm as evidence of their interest in the physician sector.

an unfavorable payer mix may further complicate assessment of creditworthiness and make gaining access to capital through traditional means difficult.

Financial Arrangements with Hospitals.

Hospitals are a source of financing for many physician practices. Over the past decade, financial arrangements between physicians and hospitals have blossomed. Forms of assistance include loan repayment and relocation assistance. Some hospitals have become more involved in direct support for start-up medical practices by launching incubator projects for physicians willing to migrate. A host of other hospital/physician initiatives also exist, although these are mainly aimed at further integrating economic and clinical activities of existing practices. In Maryland, a number of hospitals have either acquired physician practices or hold significant equity positions in practices. One concern whenever physicians and hospitals collaborate is the potential for antitrust or Stark law violations.[17]

Lending through the Small Business Administration

In some instances, the federal Small Business Administration (SBA) guarantees a loan made by a lending institution to a small business. SBA loans are designed for businesses that are lacking a lot of equity or a large down payment. Yet, SBA loans have a unique set of rules to help assure repayment. These rules include: i) businesses must operate for profit and have reasonable owner equity investment; and, ii) borrowers must demonstrate that alternative financial resources, including personal assets, have also been accessed prior to the loan application.

Medical facilities, including clinics and medical practices, are among the businesses that would be eligible for participation if they meet the 'for-profit' and owner equity requirements. The most common SBA program is the 7(a) Loan Guaranty Program. The SBA reduces risk to the lender by guaranteeing a major portion of the loan made to the small business. This enables lenders to provide financing to small businesses on reasonable terms when funding is otherwise unavailable. The 7(a) Loan Guaranty Program can be used for various types of physician practice start-up costs, including the purchase of an existing practice, facility improvements, medical equipment financing, and gaining access to working capital. The loan guarantee from the SBA may provide the necessary assurance to the lender that its funds are recoverable.

Funding of Health Information Technology through the HITECH Program in the American Recovery and Reinvestment Act

The recent American Recovery and Reinvestment Act (ARRA) through the Health Information Technology for Economic and Clinical Health (HITECH) program provides substantial funding

[17]The Federal Trade Commission (FTC) concluded that vertical alignments of hospitals and physicians often lead to negotiating prices with carriers and employers collectively without developing the requisite economic or clinical integration to meet antitrust guidelines. The Stark law prohibits physicians from making a referral to an entity with which the physician (or a family member) has a financial relationship for the furnishing of certain designated health services (DHS) that are reimbursable under federal government programs. Ambulatory surgical services are not DHS and therefore do not raise Stark issues.

for physician practices that adopt and make meaningful use of electronic health records. The HITECH program funds the initial costs and operating expenses of the practice's electronic health record system for five years. Physicians are eligible for adoption incentive payments from either the Medicare program or the Medicaid program, but not both. To be eligible to receive incentive payments from Medicaid, eligible professionals must demonstrate that a minimum of 30 percent of their patients (pediatricians must demonstrate 20 percent) are covered by Medicaid. Table 5 presents the subsidy levels, assuming the practice began implementing in 2011 or before.

Table 5 – Payments to Practices for EHR Implementation (Meeting the Meaningful Use Definition)

	Medicare	Medicaid
2011	18,000	$25,000
2012	12,000	$10,000
2013	8,000	$10,000
2014	4,000	$10,000
2015	2,000	$10,000
2016	0	$0
Total	44,000	$65,000
10% additional payment For Health Professional Shortage Areas	4,400	$0
Total	$48,400	$65,000

These funds address many of the challenges that all physician practices face in covering the initial upfront acquisition costs and operating expenses of electronic health record systems. House Bill 706 passed in the 2009 session of the Maryland General Assembly requires that private health plans that offer health benefits in Maryland establish incentive programs for health providers for meaning use of EHR systems. [18] Health plans will be able to meet this requirement in a variety of ways, and the incentives may be targeted by the carrier to specific provider groups, such as participants in a patient centered medical home program. Regulations defining the types of health plan support that are permitted under the law will be promulgated in 2010. Any Maryland-specific practice loan assistance and loan guaranty program should require that practices first obtain financial assistance for EHR acquisition through the Federal program and from private payers as required under HB 706.

6.0 DESIGNING A PRACTICE ASSISTANCE PROGRAM FOR MARYLAND

New York State developed a practice assistance program for physicians willing to work in underserved areas. The program, ***Doctors Across New York***, provides physician loan repayment

[18] Self-insured private employers protected by the federal Employer Retirement Insurance Security Act of 1974 are not covered under any of the current EHR funding requirements under Maryland law.

and practice support grants to physicians willing to work in health provider shortage areas of the State for five years.[19] Funding for practice development from the program takes one of two forms: (1) physicians may receive funding to establish or join practices in an underserved area; or (2) general hospitals, other health care facilities, and physician practices may receive funds to recruit new physicians to provide services in underserved communities by offering sign-on bonuses, income guarantees, or other financial incentives provided directly to the physician. The 2008-09 New York budget set aside $4.9 million to fund the program. Applicants selected in a competitive process are eligible for up to $100,000 per year.

To develop a practice assistance program with similar aims to the New York program, Maryland would first need to define the goals and the scope of the program. Financing practice development could be a costly operation. MHCC estimates that as much as $243,000 per physician might be needed to establish a practice (see Table 4 above). If any portion of the support was offered via a grant arrangement, a competitive process for grants would be dictated. A loan guaranty program would allow the distribution of benefits across a greater number of practice participants, but may attract fewer applicants. These programs are less costly per practice and are consistent with other economic development programs launched by the State, but may be inadequate to meet the needs of practices in dire need of funding. In tough economic times, it may be desirable to structure incentives roughly in accordance with the level of need in a given community. In communities with the greatest unmet health care needs, a combination of loan assistance and loan guarantee programs would be desirable. In communities where unmet health needs are lower, a loan guarantee alone might first be considered to develop a new practice. For other communities and for certain types of more profitable specialty practices (if included in a program) technical assistance grants might be an attractive incentive to encourage practice placement. Key design issues that need to be answered include:

- ***Should the program be limited to primary care physicians or could a physician in any specialty who is willing to establish a practice in an underserved geographic area or a specific underserved patient population qualify?*** SB 627 directed DHMH to develop state-specific health professional shortage areas that would more accurately reflect Maryland needs. These new definitions, as they will based on Maryland norms, would be an ideal basis for setting up a practice development initiative. By contrast, only about a dozen Maryland jurisdictions meet federal HPSA definitions because local physician to population ratios are higher than in many rural states. The other approach under the federal rules is to demonstrate that a defined population group has unmet health care needs or faces barriers to accessing existing health care services.

[19]See Doctors Across New York Program, New York Dept of Health. The program is a state-funded initiative enacted in 2008 to help train and place physicians in underserved communities in a variety of settings and specialties to care for New York's population.
http://www.health.state.ny.us/professionals/doctors/graduate_medical_education/doctors_across_ny/

- ***Should the assistance program(s) be limited to the practice recipients or could hospitals and communities also qualify and then distribute program funds?*** Under the New York program, community hospitals may qualify for funds to attract physicians. Allowing communities to obtain funds would encourage local groups to develop community initiatives that combine local and state resources. Allowing a community to obtain State funds as a last resort to attract a physician practice would encourage use of local resources to the fullest extent possible.

- ***Should practice development assistance be linked to demonstrated community commitment?*** A physician practice requires community support to maintain viability. The community provides the patient base and without an adequate patient panel, a physician practice will not survive. The media often document the extent to which communities will go to attract a primary care physician or an obstetrician.[20] Community commitments, as measured by capital investments, in-kind contributions such as a rent-free facility, favorable lease conditions, or waivers of local tax levies, could be used as one criterion for establishing eligibility. Other considerations make imposing a community contribution commitment less attractive. If the commitment is based simply on financial measures, physicians willing to practice in the poorest communities with the greatest needs might have the most difficulty qualifying for assistance programs. Any community commitments that would be used should encompass more than financial measures and any financial measures that are used should be scaled with underlying resources of the community.

- ***How much funding should be committed to any one practice***? Two approaches have been identified. If a grant, loan, or loan guarantee program is implemented, capital could be made available up to the difference between total start-up costs and the owner's (physician's) equity position. If a physician committed 25 percent of the total start-up costs, the loan assistance or a loan guarantee could cover up to 75 percent of the total start-up costs. Under the equity position approach, the underlying principal for the loan or guarantee could be limited to 50 percent or less of the total start-up costs. If funds were available, DBED's loan assistance and loan guaranty programs with $2 million statutory lending ceilings would appear sufficient to meet capital needs of most practices. The practical ceiling on loans and loan guarantees to any applicant is much lower. As will be discussed below, the current capital base of these DBED programs cannot sustain significant increases in volume of loans or in the size of the typical loan.

- ***What is the source of the new funding?*** Identifying a source of funds for a physician start-up will be most challenging as the State faces a long-term structural deficit. Even as the State climbs out of the worst economic turbulence since the Great Depression, new

[20] Philip Rucker, The only doctor in town, Washington Post, Saturday, December 5, 2009.

general funding opportunities appear limited. Unless federal funding becomes available, or some of the SB 627 State-only physician loan assistance repayment program funds can be allocated to practice assistance, prospects for launching a program in any form through loans, loan guarantees, or interest subsidies appear limited.

Given the current fiscal climate, it is practical to consider first if existing DBED programs could be expanded to meet the needs of an assistance program. The feasibility of using the existing DBED programs as a starting point is briefly analyzed next.

Establish a Practice Development Program through DBED's Maryland Small Business Development Financing Authority (MSBDFA) One possible option would be to expand the existing assistance program in MSBDFA. The MSBDFA has existed since 1978 and has an established track record of success in assisting small businesses in the State. MSBDFA is already structured to support small businesses through a variety of products -- loan assistance, loan guarantee, and an equity participation program. It is already welled targeted at small, minority, and women-owned businesses that do not meet the criteria for normal lending from financial institutions.

Current MSBDFA programs are well-positioned to support eligible businesses throughout the State. Statutory ceilings on loan assistance and loan guarantees are currently set at $2 million dollars, but the current capital base of the program will realistically only support loans in the $50,000 – $150,000 range per applicant. Loan ceilings in this lower range could be sufficient to finance the establishment of a solo practice or a small group practice, but would not meet capital requirements of single or multispecialty group practices. If physician practices are to be included without compromising current program clients, the capital base of MSBDFA would need to be expanded to enable loans or loan guarantees to the new client group. Bigger loans to single or multispecialty practices with greater capital needs will require a substantial capital infusion to the financial base of MSBDFA.

Establish a Medical Practice Technical Support Program Using The Strategic Assistance Consulting Fund (SACF). This DBED-monitored fund provides basic consultative support to small businesses throughout Maryland. SACF currently lacks specialists to assist physicians in conducting the business and practice planning that should occur prior to practice start-up. The SACF regional centers are supported by Maryland institutions of higher education in the jurisdictions, so over time these organizations should be able to provide staff with particular expertise in practice development. In the short term, DBED could consider establishing contractual arrangements with business organizations with expertise in practice development. One major limitation of the current program is a cap of $5,000 on consulting for any organization. This threshold would likely be too low even for smaller practices composed of one or two physicians.

7.0 FEASIBILITY OF USING PRACTICE ASSISTANCE FUNDS TO SUPPORT THE ADOPTION OF PATIENT CENTERED MEDICAL HOMES

Senate Bill 627 charged the MHCC with considering if DBED funds could be used to finance expenses associated with transitioning a primary care practice to a new model of advanced primary care called a Patient Centered Medical Home (PCMH). Converting a primary care practice to a PCMH involves significant changes, including practice management redesign, medical staff transformation, clinician and patient behavior modification, communication enhancement, and electronic medical record system implementation. These changes are thought to lower the total costs of care, improve clinical care processes, increase patient access, enhance patient experience of care, and improve staff work satisfaction. Many of the costs for achieving PCMH recognition are akin to the start-up costs for a practice.

Estimates on the cost of converting a primary care practice to a PCMH diverge widely depending on the assumptions made regarding the starting point for a primary care practice and whether the endpoint is achieving PCMH recognition through a national accreditation entity or operating as a PCMH. One of the first and most systematic studies conducted for the American Academy of Family Medicine's Future of Family Medicine by Lewin Associates found that the cost of the transition to a PCMH model, referred to as the New Model in the study, was estimated to range from $23,442 to $90,650 per physician, depending on the assumed magnitude of productivity loss associated with implementing an electronic health record.[21] Based on their estimates of the costs of implementation and operation and its effect on outcomes, Lewin concluded that under current payment policies a physician in a five-physician family practice could earn the same net income under the PCMH model by working 12 percent fewer hours, or could earn 26 percent more income by working the same hours as under the current system. Lewin's conclusion that adoption of the model could lead to higher reimbursement does raise a question on whether scarce state funds should be used when private financing might be accessible.

Pennsylvania, one of the first states to attempt to implement this new advanced primary care model, has developed estimates for implementing and operating a PCMH. The Chronic Care Commission, the organization charged with implementing the program, establishes subsidy levels for practices in the program. The Pennsylvania experience is especially relevant given its proximity to Maryland and substantial evidence that primary care practices in Pennsylvania find these funding levels acceptable, as evidenced by the participation levels in the program for these practices. Solo practices are eligible for approximately $21,000 in initial infrastructure funding to the cover cost of the recognition tools, disease registry, and the clinician/practice training on the PCMH care delivery approach. Practices that achieve PCMH recognition receive a lump sum payment that reflects the ongoing operating costs associated with functioning as a PCMH. This lump sum payment translates into approximately a $4 per member per month payment (PMPM) assuming 1,250 patients participate in the PCMH. Infrastructure and operating costs associated

[21] Stephen Spam, MD, MBA, Task Force Report 6. Report on Financing the New Model of Family Medicine, Annuals of Family Medicine. 2004 Dec 2; 2, Supplement 3: S 1-21.

with the PCMH decrease as practice size increases. Table 6 presents MHCC's estimates of start-up and operating costs as a function of practice size, using Pennsylvania costs assumptions. Under the Pennsylvania program, the private payers fund these costs for the initial three years of the program in rough proportion to each payer's market share.

Table 6 – Estimated Infrastructure and Operating Costs Associated with a PCMH

	1 FTE Practice	4 FTEs Practice	9 FTEs Practice
Infrastructure costs includes $12K per clinician in training expenses	$21,000	$14,500	$13,000
Annual incremental costs per clinician for operating as a PCMH at NCQA PPC PCMH Level II functionality	$60,000	$54,000	$48,000
Total per FTE clinician	$81,000	$68,500	$61,000

Source: Liss Donald, MD "Transforming Primary Care Practice: The Southeast Pennsylvania Rollout", presentation to the Maryland Health Quality and Cost Council PCMH Workgroup, May 20, 2009

A more recent study conducted by a team of researchers from the Urban Institute on behalf of the Commonwealth Fund found relatively small incremental costs associated with the transition to a PCMH.[22] The authors found no evidence of additional costs associated with higher levels of PCMH achievement, with the exception of higher information technology costs. These authors suggest that given their finding of a weak relationship between costs and PCMH levels, becoming a PCMH may only require adjustments to how existing practice inputs are used, rather than significant additional expenditures. This study focuses on achieving NCQA's PPC-PCMH recognition, not operating as a PCMH practice. Some ongoing costs of serving as a PCMH could not be included in the recognition program, or could not be fully captured. The authors caution that their estimates may not fully capture expenditures of a physician's own time that may be needed to improve patient-centeredness of the practice. This warning only partially undercuts the chief finding that EHR costs are the largest incremental cost of adoption. These costs are now subsidized by the new federal and Maryland programs. Residual costs of implementing the PCMH might be lower than first thought.

Current approaches for financing the introduction of a PCMH model have largely been absorbed by payers through member per month payments for patients treated by PCMH practices. As noted for Pennsylvania, a lump sum payment is made, which roughly equates to $4 per member per month. This financing mechanism should be encouraged to the extent possible. One

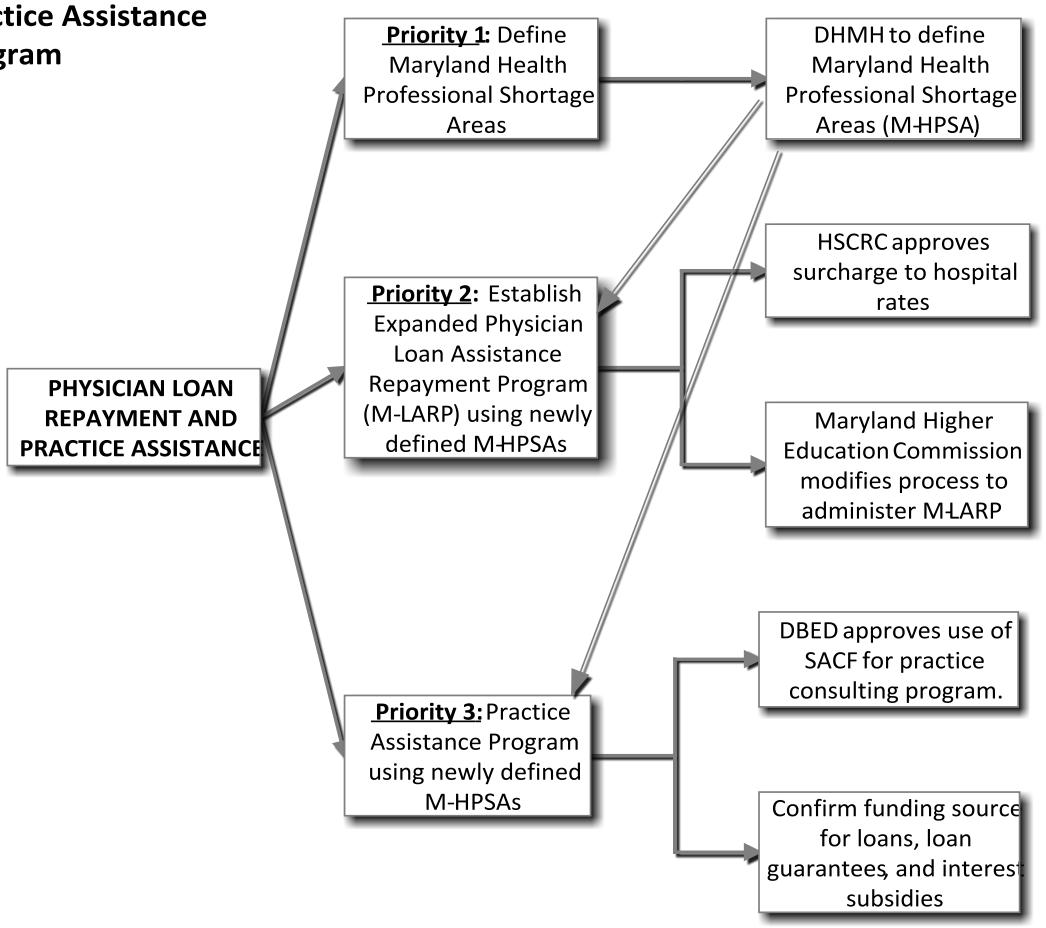
[22] Zuckerman Stephen, Merrell Katie, Berenson Robert, Gans David, Underwood William, Williams Aimee, Erickson Shari, and Hammons Terry, *Incremental Cost Estimates For The Patient-Centered Medical Home*, Commonwealth Fund, December 2009

outstanding challenge faced by many of these pilot projects is assisting practices in obtaining the consulting expertise needed to make the transformation. Only a handful of firms across the US are currently equipped to assist in these efforts. A low cost approach that Maryland may wish to consider is making consulting expertise from these firms available through the SACF administered by DBED. Consulting assistance is limited to $5,000, but if those funds could used for consulting with firms having expertise in PCMH implementation, the funds would be well-targeted and useful.

8.0 RECOMMENDATIONS

A practice assistance program focusing on loan assistance and interest subsidies is a worthwhile tool for attracting physicians, particularly primary care physicians, to Maryland and especially to health professional shortage areas of the state. One possible model for a future program may be New York's physician loan repayment and practice assistance program. Given the State's current budget crisis, any funds to finance a physician loan assistance repayment and practice loan assistance program must likely come from either special funds or the hospital rate-setting system. A ranking by priority of need is necessary and some elements of a program will need to be deferred until the economic outlook improves. Figure 2 presents a visualization of the elements of the program and the sequence for implementation. A discussion of the four recommendations then follows.

Figure 2 --Priorities for a Establishing Physician Loan Repayment and Practice Assistance Program



1. The new health professional shortage area definitions being developed by DHMH should qualify areas of the state for participation in the physician loan assistance repayment program and in the practice assistance program, if established. The new health professional shortage area definitions will reflect Maryland, not national, norms and will address geographically-defined and income-based access problems. Using a consistent set of definitions will ensure that assistance is targeted at the areas of recognized need. ***Devising the new definitions can be completed with existing state resources, has no fiscal impact, and can be accomplished within the framework established under SB 627.***

2. The State's second priority should be to identify funding for the State-only loan assistance repayment program. Senate Bill 627 establishes a new State-only Loan Assistance and Repayment program. Work is underway in the Office of Primary Care at DHMH to devise new health professional shortages areas specific to the State, as described above. It is envisioned that

up to a 0.5 percent surcharge could be applied to hospital rates via the hospital rate-setting system to fund a loan repayment program. HSCRC has not approved the surcharge because CMS believes that Maryland cannot use Medicare hospital payments to finance a physician loan repayment program. The State should first focus on funding for the State-only loan assistance repayment program. This program will have broader application than a practice loan assistance and subsidy program because loan repayment can support physicians in a variety of practice settings, including private practice, community health centers, and local health departments.

3. The third priority is a practice development program focusing on loan assistance that could be useful for attracting physicians, especially primary care physicians, to health professional shortage areas in Maryland. The level of support to attract practices could be significant. MHCC estimates that family practitioners and pediatricians require from $99,000 to $230,000 per physician in start-up funds above their own equity commitment. The likely passage of a final national health care reform bill increases the urgency for expanding the number of primary care practices in shortage areas. DBED's Guaranty Fund and Equity Participation Investment Programs could serve as models for a practice development program.

4. The State should support multi-payer initiatives targeted toward financing practice innovations, such as implementation of new practice models, including the patient centered medical home. The Maryland Health Quality and Cost Council has taken the initiative in establishing a patient centered medical home pilot. Financing of the initiative should be largely through supplemental payments by health plans to participating practices. Long-term, this pilot could lead to improved quality of care for patients at a lower overall cost. Given this objective, it is prudent to limit the new health care dollars injected into the system. The SACF technical assistance program may be a possible vehicle for arranging consulting support to practices needing help in reorganizing the clinical, administrative, and business operations required of a PCMH.